PH: 704-848-6225
EMAIL: APRIL@ALELBEAUTYBOUTIQUE.COM

GLH FOUNDATION

Physician Certification of Medical Necessity

Date: _____

Patient Information

Name: _____ DOB: _____

Phone: _____ Email: _____

Address: _____ City, State, Zip: _____

Insurance: _____ ID#: _____ Group#: _____

☐	HCPCS Code and Product	Qty	Diagnosis Code	Length of Need
☑	**A9282** Cranial Prosthesis/Wig	1	C _____ *(Cancer Code)* L _____ *(Alopecia Code)*	

Physician Information

Facility Name: _____ NPI: _____

Address: _____ City, State, Zip: _____

Physician Name: _____ Physician Phone #: _____

Physician Signature: _____ Date: _____

Please return completed RX form by email, april@alelbeautyboutique.com
www.glhfoundation.com